

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0039545</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Greenwood Manor West</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>608 West Pearl</u> <u>Jerseyville</u> <u>62052</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Jersey</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(618) 498-4312</u> Fax # <u>(618) 498-9575</u>		(Type or Print Name) <u>Barbara Molloy</u>	
IDPA ID Number: <u>371324091001</u>		(Title) <u>Administrator</u>	
Date of Initial License for Current Owners: _____		Paid Preparer (Signed) _____ (Date) _____	
Type of Ownership:		(Print Name and Title) <u>Dennis E. Ulrich, Certified Public Accountant</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Scheffel & Company, P.C.</u> <u>143 North Kansas Street, Edwardsville, IL 62025</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(618) 656-1206</u> Fax # <u>(618) 656-3536</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Barbara Molloy</u> Telephone Number: <u>(618) 498-4312</u>			

Facility Name & ID Number Greenwood Manor West# 0039545 Report Period Beginning: 1/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>48</u>	Intermediate (ICF)	<u>48</u>	<u>17,520</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>48</u>	TOTALS	<u>48</u>	<u>17,520</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>9,963</u>	<u>4,289</u>		<u>14,252</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,963</u>	<u>4,289</u>		<u>14,252</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 81.35%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 04/05/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 04/05/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Greenwood Manor West

0039545

Report Period Beginning:

1/01/02

Ending:

12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	65,890	9,449	4,794	80,133		80,133		80,133			1
2	Food Purchase		69,137		69,137		69,137		69,137			2
3	Housekeeping	37,001	6,049		43,050		43,050		43,050			3
4	Laundry	35,445	15,098		50,543		50,543		50,543			4
5	Heat and Other Utilities			38,894	38,894		38,894		38,894			5
6	Maintenance			28,015	28,015		28,015	1,865	29,880			6
7	Other (specify):*											7
8	TOTAL General Services	138,336	99,733	71,703	309,772		309,772	1,865	311,637			8
	B. Health Care and Programs											
9	Medical Director			1,000	1,000		1,000		1,000			9
10	Nursing and Medical Records	422,163	37,506	4,783	464,452		464,452		464,452			10
10a	Therapy	1,333		2,360	3,693		3,693		3,693			10a
11	Activities	17,344	4,245	5,044	26,633		26,633		26,633			11
12	Social Services	16,770			16,770		16,770		16,770			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	457,610	41,751	13,187	512,548		512,548		512,548			16
	C. General Administration											
17	Administrative	27,868		6,326	34,194		34,194	(6,326)	27,868			17
18	Directors Fees											18
19	Professional Services			11,461	11,461		11,461		11,461			19
20	Dues, Fees, Subscriptions & Promotions			10,713	10,713		10,713	(8,452)	2,261			20
21	Clerical & General Office Expenses	23,132	7,457	21,026	51,615		51,615	(218)	51,397			21
22	Employee Benefits & Payroll Taxes			109,523	109,523		109,523		109,523			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,282	2,282		2,282		2,282			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			33,802	33,802		33,802		33,802			26
27	Other (specify):*											27
28	TOTAL General Administration	51,000	7,457	195,133	253,590		253,590	(14,996)	238,594			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	646,946	148,941	280,023	1,075,910		1,075,910	(13,131)	1,062,779			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Greenwood Manor West

#0039545

Report Period Beginning:

1/01/02

Ending:

12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			17,379	17,379		17,379	14,687	32,066			30
31	Amortization of Pre-Op. & Org.			467	467		467		467			31
32	Interest			30,354	30,354		30,354	14,011	44,365			32
33	Real Estate Taxes							4,973	4,973			33
34	Rent-Facility & Grounds			21,600	21,600		21,600	(21,600)				34
35	Rent-Equipment & Vehicles			7,169	7,169		7,169		7,169			35
36	Other (specify):*											36
37	TOTAL Ownership			76,969	76,969		76,969	12,071	89,040			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,280	26,280		26,280		26,280			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			26,280	26,280		26,280		26,280			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	646,946	148,941	383,272	1,179,159		1,179,159	(1,060)	1,178,099			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Greenwood Manor West

0039545

Report Period Beginning: 1/01/02

Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,197	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,326)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(230)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,301)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,132)	20		28
29	Other-Attach Schedule PAC Dues	(19)	20		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,811)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	3,751		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 3,751		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,060)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Greenwood Manor WestID# 0039545Report Period Beginning: 1/01/02Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	PAC Dues	\$ (19)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19)		49

Summary A

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

12/31/02

[illegible]

Facility Name & ID Number Greenwood Manor West# 0039545

Report Period Beginning:

1/01/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Lawrence B. Plummer	100.0	Greenwood Maonor, Inc.	Jerseyville			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	21 Clerical	\$	Lawrence Plummer	100.00%	\$ 12	\$ 12
2	V	30 Depreciation		Lawrence Plummer	100.00%	4,490	4,490
3	V	32 Interest		Lawrence Plummer	100.00%	14,011	14,011
4	V	33 Real Estate Taxes		Lawrence Plummer	100.00%	4,973	4,973
5	V	34 Rent	21,600	Lawrence Plummer	100.00%		(21,600)
6	V	6 Repairs		Lawrence Plummer	100.00%	1,865	1,865
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 21,600			\$ 25,351	\$ * 3,751

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Greenwood Manor West # 0039545 Report Period Beginning: 1/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Barbara Molloy	Administrator	Administration	0.00	17,871	40	100.00	Wages	\$ 27,868	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,868		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Greenwood Manor West# 0039545

Report Period Beginning:

1/01/02Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Greenwood Manor/refinance First Bank	X		Building Improvements		04/19/02	\$ 195,197	\$ 195,197	10/19/03	7.0000	\$ 9,266	1	
2	Greenwood Manor/refinance First Bank	X		Operating Loan		04/19/02	302,000	302,000	10/19/03	7.0000	13,899	2	
3	State Bank of Jerseyville		X	Building Improvements	\$2,989.00	10/26/94	300,000		04/19/02	8.7500	4,745	3	
4												4	
5												5	
	Working Capital												
6	First Bank		X	Operating Line of Credit		04/19/02		6,000		Prime + 1.5%	965	6	
7	State Bank of Jerseyville		X	Operating Loan		11/16/00	242,000		04/19/02	Prime + 1%	15,490	7	
8												8	
9	TOTAL Facility Related				\$2,989.00		\$ 1,039,197	\$ 503,197			\$ 44,365	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,039,197	\$ 503,197			\$ 44,365	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Greenwood Manor West**# **0039545** Report Period Beginning: **1/01/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 4,974	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 4,974	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 4,974	7

Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	4,575	8	
	1998	4,575	9	
	1999	4,654	10	
	2000	4,543	11	
	2001	4,543	12	

Line 2 is 2001 taxes paid in 2002.				

FOR OHF USE ONLY				
13	FROM R. E. TAX STATEMENT FOR 2001	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Manor West COUNTY Jersey

FACILITY IDPH LICENSE NUMBER 0039545

CONTACT PERSON REGARDING THIS REPORT Barbara Molloy

TELEPHONE (618) 498-4312 FAX #: (618) 498-9575

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-562-002-00</u>	<u>Hill's Addition Lot 1, 2, 5, 6</u>	\$ <u>451.84</u>	\$ <u>451.84</u>
2. <u>04-562-001-00</u>	<u>Hill's Addition Lot 2, 3, 5</u>	\$ <u>4,521.82</u>	\$ <u>4,521.82</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>4,973.66</u></u>	\$ <u><u>4,973.66</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 13,668

B. General Construction Type:
 Exterior
 BLOCK
 Frame
 WOOD
 Number of Stories
 ONE

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:
 11,957

2. Number of Years Over Which it is Being Amortized:
 5 - 15 YEARS

3. Current Period Amortization:
 467

4. Dates Incurred:
 4/94 Legal, 10/94 Noncompete Agreement, Goodwill, Patient list

Nature of Costs:
 Legal - \$4,957, Noncompete Agreement - \$5,000, Goodwill & Patient list - \$2,000

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	To accommodate Bldg.			\$	1
2	and Parking	28,741	1994	25,000	2
3	TOTALS	28,741		\$ 25,000	3

Facility Name & ID Number Greenwood Manor West

0039545

Report Period Beginning:

1/01/02

Ending:

12/31/02

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1994		\$ 175,130	\$ 4,491	40	\$ 4,491	\$	\$ 36,386	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling		1994		80,562	2,066	30	2,685	619	22,923	9
10	Call Lite System		1994		13,123		15	875	875	7,363	10
11	Door Control System		1994		3,858		20	193	193	1,591	11
12	Blinds, Rods, Drapes, & Curtains		1994		14,238		12	1,186	1,186	9,303	12
13	Cabinets		1994		3,702		20	185	185	1,496	13
14	Monitor, Cameras, & Closed Circuit TV		1994		5,619		20	281	281	2,365	14
15	Flooring		1994		1,946		8	81	81	1,946	15
16	Air Conditioners		1994		2,341		8	98	98	2,341	16
17	Over-the-bed Light Fixtures		1994		4,510		8	235	235	4,510	17
18	Carpet		1994		38,729		5			38,729	18
19	HVAC System		1994		29,750	763	20	1,487	724	12,768	19
20	Fire Alarm System		1994		989		20	49	49	416	20
21	Handicap Water Cooler		1994		995		10	99	99	805	21
22	Shampoo Bowl		1994		233		10	23	23	188	22
23	Water Heater		1994		5,149		15	343	343	2,775	23
24	Remodeling		1995		436	11	30	15	4	116	24
25	Remodeling		1995		160	4	30	6	2	43	25
26	Door Control Keypad		1995		273	12	20	14	2	109	26
27	Remodeling		1995		625	16	30	21	5	165	27
28	Remodeling		1995		478	12	30	16	4	124	28
29	Tile Floor		1995		266	12	8	33	21	258	29
30	Light Fixtures		1995		198	9	8	25	16	191	30
31	Laundry Room Remodeling		1995		12,793	328	30	426	98	3,305	31
32	Heating Duct Work		1996		8,250	212	20	413	201	2,578	32
33	Landscaping		1997		3,535	555	20	177	(378)	1,002	33
34	Remodeling- Fire Walls, etc.		2000		7,810	195	40	195		439	34
35	Rewiring		2000		6,169	154	40	154		373	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	Ceiling Fans	7/19/2001	\$ 1,062	\$ 260	15	\$ 106	\$ (154)	\$ 150	37
38	Boiler in Mechanical Room	1/27/2001	4,200	399	20	210	(189)	403	38
39	Painting	4/3/2001	2,128	202	5	426	224	745	39
40	Asphalt Driveway, Sides & Back	9/17/2001	5,242	498	8	655	157	819	40
41	2 Fire-Rated Doors - Dietary	11/13/2001	1,053	258	20	53	(205)	61	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 435,552	\$ 10,457		\$ 15,256	\$ 4,799	\$ 156,786	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 167,987	\$ 9,398	\$ 16,537	\$ 7,139		\$ 107,896	71
72	Current Year Purchases	4,930	2,014	94	(1,920)	15	94	72
73	Fully Depreciated Assets	6,064		179	179		6,064	73
74								74
75	TOTALS	\$ 178,981	\$ 11,412	\$ 16,810	\$ 5,398		\$ 114,054	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 639,533	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,869	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,066	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 10,197	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 270,840	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 7,169 Description: \$982 Postage Meter, \$282 Pagers, \$596 Dishwasher, \$5,309 Oxygen Equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

Aides are responsible for training fees, not the facility.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$			\$			\$	1				
2	Licensed Speech and Language Development Therapist		hrs								2				
3	Licensed Recreational Therapist		hrs								3				
4	Licensed Physical Therapist	10a-1	5 hrs	289				5	289		4				
5	Physician Care		visits								5				
6	Dental Care		visits								6				
7	Work Related Program		hrs								7				
8	Habilitation		hrs								8				
9	Pharmacy		# of prescrpts								9				
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10				
11	Academic Education		hrs								11				
12	Exceptional Care Program										12				
13	Other (specify):										13				
14	TOTAL			\$ 289		\$	\$	5	\$ 289		14				

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	275,757	275,757	3
4	Supply Inventory (priced at <u>COST</u>)	3,000	3,000	4
5	Short-Term Investments			5
6	Prepaid Insurance	6,215	6,215	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		230,281	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 284,972	\$ 515,253	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	7,242	7,242	11
12	Long-Term Investments			12
13	Land		25,000	13
14	Buildings, at Historical Cost		175,130	14
15	Leasehold Improvements, at Historical Cost	260,422	260,422	15
16	Equipment, at Historical Cost	178,981	178,981	16
17	Accumulated Depreciation (book methods)	(287,992)	(324,852)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	11,957	11,957	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(9,468)	(9,468)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>DEPOSITS</u>	3,225	3,225	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 164,367	\$ 327,637	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 449,339	\$ 842,890	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 112,503	\$ 112,503	26
27	Officer's Accounts Payable	688,902	688,902	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	29,113	29,113	29
30	Accrued Salaries Payable	28,331	28,331	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,027	2,027	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO AFFILIATES</u>	415,856	625,293	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,276,732	\$ 1,486,169	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,276,732	\$ 1,486,169	46
47	TOTAL EQUITY (page 18, line 24)	\$ (827,393)	\$ (643,279)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 449,339	\$ 842,890	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (751,355)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (751,355)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(76,038)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (76,038)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (827,393)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,103,121	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,103,121	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,103,121	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	309,772	31
32	Health Care	512,548	32
33	General Administration	253,590	33
	B. Capital Expense		
34	Ownership	76,969	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	26,280	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,179,159	40
41	Income before Income Taxes (line 30 minus line 40)**	(76,038)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (76,038)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, cash basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Greenwood Manor West# 0039545Report Period Beginning: 1/01/02Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,912	2,080	\$ 36,325	\$ 17.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,655	1,655	27,081	16.36	3
4	Licensed Practical Nurses	10,378	10,855	136,490	12.57	4
5	Nurse Aides & Orderlies	23,843	24,945	222,267	8.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5	5	289	57.80	7
8	Rehab/Therapy Aides	80	85	1,044	12.28	8
9	Activity Director	1,769	1,996	17,179	8.61	9
10	Activity Assistants	26	26	165	6.35	10
11	Social Service Workers	1,821	1,955	16,770	8.58	11
12	Dietician					12
13	Food Service Supervisor	1,803	2,000	17,175	8.59	13
14	Head Cook	3,253	3,328	24,385	7.33	14
15	Cook Helpers/Assistants	3,602	3,602	24,330	6.75	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	4,774	4,894	37,001	7.56	18
19	Laundry	4,520	4,867	35,445	7.28	19
20	Administrator	1,960	2,080	27,868	13.40	20
21	Assistant Administrator					21
22	Other Administrative	170	170	1,329	7.82	22
23	Office Manager	1,912	2,080	21,803	10.48	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	63,483	66,623	\$ 646,946 *	\$ 9.71	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	105	\$ 4,794	1-3	35
36	Medical Director		1,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	varies	960	10-3	39
40	Physical Therapy Consultant	29	1,725	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	635	10a-3	43
44	Activity Consultant	90	5,044	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Care Plan Consultant	103	3,503	10-3	47
48					48
49	TOTAL (lines 35 - 48)	331	\$ 17,661		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	8	320	10-3	52
53	TOTAL (lines 50 - 52)	8	\$ 320		53

Facility Name & ID Number Greenwood Manor West# 0039545Report Period Beginning: 1/01/02Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%			Description			Description			
Barbara Molloy	Administrator	0	\$	27,868	Workers' Compensation Insurance	\$	43,832	IDPH License Fee	\$		
					Unemployment Compensation Insurance		12,476	Advertising: Employee Recruitment		770	
					FICA Taxes		50,015	Health Care Worker Background Check			
					Employee Health Insurance			(Indicate # of checks performed <u>11</u>)		171	
					Employee Meals			Dues and Subscriptions		1,099	
					Illinois Municipal Retirement Fund (IMRF)*			Advertising and Promotion		8,433	
					Other Employee Benefits		3,100	Taxes & Licenses		240	
					Employee Physicals		100	SUBTOTAL		10,713	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$	27,868						
B. Administrative - Other											
Description				Amount							
Sales Tax				\$	6,326			Less: PAC Dues			(19)
								Less: Public Relations Expense			(4,301)
								Non-allowable advertising (
								Yellow page advertising			(4,132)
TOTAL (agree to Schedule V, line 17, col. 3)				\$	6,326			TOTAL (agree to Sch. V, line 20, col. 8)			\$
(Attach a copy of any management service agreement)											
C. Professional Services								G. Schedule of Travel and Seminar**			
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description				Amount
Automated Data Processing	Payroll	\$	4,402				Out-of-State Travel				\$
Scheffel & Company, P.C.	Accounting		4,868								
Farrell Law Firm	Legal		165				In-State Travel				
Stratton, Giganti, Stone	Legal		1,380								
McMahon, Berger	Legal		46								
Ross Breitweiser	Computers		600				Seminar Expense				2,282
							Entertainment Expense (
							(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)					TOTAL						\$
(If total legal fees exceed \$2500 attach copy of invoices.)				\$	11,461						2,282

* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number **Greenwood Manor West**

STATE OF ILLINOIS

0039545

Report Period Beginning:

1/01/02

Ending:

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12/31/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Healthcare Assoc. \$225
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,488 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 26,280
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A <\$2,500
Attach invoices and a summary of services for all architect and appraisal fees.